Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Resilience Health, Cardiff

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective and high-quality for everyone.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Resilience Health on 9 June 2026. As Resilience Health is a fully virtual service, HIW met with the registered manager and reviewed patient records, policies, procedures and other documentation through the setting's electronic portal. As patients do not physically visit the service, HIW did not inspect the staff premises.

Our team for the inspection comprised of a HIW healthcare inspector and a clinical peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of one questionnaire was completed by patients or their carers. Feedback and some of the comments we received appear throughout the report. Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

The service demonstrated a positive, person-centred approach to supporting patients through a virtual consultation model. Patients were provided with tailored health promotion advice during consultations, with information adapted to their cultural background, presenting needs and individual circumstances. The service also made health promotion information available through its website and blogs, with a recommendation to strengthen this further by ensuring content is regularly reviewed, updated and clearly signposts people to appropriate support.

There were clear strengths in relation to privacy, dignity and informed consent. Consultations were undertaken virtually from a private setting, patients could choose appointment times that suited their circumstances and consent processes were supported by a written policy and clear documentation. Communication with patients appeared effective, with information provided about the scope and limitations of the service, treatment options, costs and escalation routes where needs fell outside the service's remit.

This is what we recommend the service can improve:

- Strengthen documentation and assurance processes
- Ensure referrals are clearly recorded, monitored and followed up
- Formalise arrangements for second opinions and shared care.

This is what the service did well:

- Their approach to equality and diversity
- Maintaining privacy, dignity and obtaining informed consent
- Consideration of communication and accessibility needs.

Delivery of Safe and Effective Care

Overall summary:

There were generally positive arrangements for delivering safe, secure and effective remote healthcare. Overall, there was evidence of clear governance, appropriate policies and procedures as well as a strong focus on confidentiality, information security and patient safety. The service operated through secure electronic systems, with no paper records held, restricted access to patient information, encrypted communication and appropriate consideration of General Data Protection Regulation (GDPR) requirements. The remote consultation model was supported by documented processes to determine clinical suitability, with arrangements in place to signpost patients to alternative or face-to-face services where required.

Key positives included the service's proactive approach to maintaining professional knowledge through continuous professional development (CPD), conferences, regulatory alerts and relevant guidance from statutory bodies and Royal Colleges. Safeguarding arrangements were also positive, with an up-to-date policy and a trained safeguarding lead in place. In addition, the service demonstrated a commitment to quality improvement through patient feedback, complaints review, reflective case analysis and participation in professional assurance processes.

There were no significant concerns identified. Some clinical audit activity had taken place, however, increasing audit activity and further developing existing processes would better support continuous quality improvement. This would provide additional assurance that the service continued to monitor outcomes, identify learning and maintain safe, effective and person-centred care.

This is what we recommend the service can improve:

- Strengthen the current audit programme.

This is what the service did well:

- Proactive approach to maintaining professional knowledge
- The availability and ongoing review of key policies
- Commitment to quality improvement.

Quality of Management and Leadership

Overall summary:

The service demonstrated generally positive and proportionate governance, leadership and workforce arrangements, appropriate to its size and operating model. Clear accountability was in place, with the Registered Individual and Registered Manager roles held by the sole doctor providing the service. The provider had developed a range of relevant policies covering key areas such as safeguarding, consent, records management, equality and diversity, and assessment and treatment. The HIW registration certificate was available on the service website and the service confirmed appropriate indemnity arrangements were in place.

There was a clear governance structure, a variety of key policies were in place and the provider showed a strong commitment to maintaining professional knowledge through training, research, reflective learning and continuing professional development. The complaints process was also well developed.

No significant concerns were identified. Overall, the service appeared well managed, with arrangements that were proportionate, responsive and supportive of safe, effective care.

This is what the service did well:

- Clear governance structure
- Well defined complaints process and supporting documentation
- Providers approach to continuous learning and development.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at Resilience Health, Cardiff for the inspection in June 2026. In total, we received one response from a patient at this setting. The patient commented:

> "*Dr Rini has been exceptional. What I value most is that she combines a genuinely holistic view of health with real intelligence, rigour and attention to detail. She does not just throw generic wellness advice around but takes the time to understand the full picture, join the dots across symptoms, bloodwork, lifestyle and longer-term risks and then explain things in a way that is thoughtful, clear and actionable.*"

Health promotion, protection and improvement

The service demonstrated that it supported people to live healthier lives through personalised health promotion during consultations, with advice tailored to the individual's cultural background, presenting condition and specific health needs.

Health promotion information was also available through the service website, including blog posts, although the primary approach was through direct discussion with patients. Information provided included nutrition, movement, emotional wellbeing and psychological health, with advice adapted according to the service offered and the needs identified during consultation. The service also described keeping up to date with relevant changes and sharing information when appropriate.

The registered manager must strengthen the accessibility and consistency of its health promotion information by ensuring the website and blog content are regularly reviewed, updated and clearly signpost people to appropriate sources of further support.

Dignity and respect

The clinic was set up in a manner that protected the privacy and dignity of all patients that accessed the service. We were told that consultations were virtual only and were delivered through an online application. The consultation took place from a private room within the doctor's main residence. We were told that the room provided full privacy with confidential conversations protected from being overheard by others on

the premise. We were told that during the consultation, the only door to the room remained closed to avoid disturbances.

Patients were given the option of time when considering booking. This allowed patients to book when they could engage in the consultation privately and at their own convenience. Chaperones were not required as all appointments were virtual.

Patient information and consent

There were processes in place for obtaining informed consent. Patients were provided with appropriate information to enable them to make informed decisions about their care. The arrangements for obtaining informed consent were supported by a written consent policy that was reviewed in April 2026. Patients were provided with information about the nature of the service, including the limitations of the remote advisory model, prior to assessment, examination or clinical recommendations being made. Consent was documented within the patient record and included details of the information provided, any questions raised by patients and their agreement to proceed.

Arrangements were in place to support effective communication with patients. We were told the registered manager (RM) provided information about proposed treatments in a clear and understandable way, including the purpose of treatment, potential risks, benefits and available alternatives. This included recognising the importance of meeting individual communication needs and made use of written information and visual aids to support patient understanding.

Patient confidentiality and information governance were considered as part of the consent process. Patients were informed about the secure nature of virtual consultation platforms and consent was obtained before these technologies were used. This helped ensure patients understood how their information would be managed and shared during remote consultations.

The service operated within a clearly defined scope of practice and appropriate escalation arrangements were in place. Where clinical concerns were identified that fell outside the service's remit or require urgent assessment, patients were directed to their GP, specialist services or emergency care as appropriate. Clear escalation pathways were communicated to patients from the outset.

Communicating effectively

We were told that key patient information, including the statement of purpose and patients' guide, was sent to patients through the clinical system. The service assessed each patient's preferred language and communication needs at initial contact, recording these preferences and updating them where required. Information was primarily provided in English, but the service stated it would take reasonable steps to source translation or interpretation support where needed, including for patients who wished to receive information or communicate in Welsh.

The provider described arrangements for tailoring information to individual needs, including consultation notes, the patients' guide, follow-up information and post-treatment instructions. Treatment options and next steps were documented and shared with patients. Information about treatment and service costs was provided at the point of enquiry.

Care planning and provision

The evidence reviewed indicated that the service took a case-by-case approach to referrals and onward communication with other healthcare professionals. Where required, referrals or letters may be written to the patient's GP and patients were made aware that the service clinician was not acting as their GP. The service appeared to support patients by offering to communicate with primary care on their behalf, rather than simply directing them to make their own arrangements. However, the recorded evidence would benefit from clearer detail about how referrals were tracked, followed up and documented to ensure continuity of care.

Arrangements for second opinions and shared care appeared to be informal and based on professional discussion with peer networks, including anonymised discussion with wider clinical peers. This provided some evidence that the clinician seeked professional input where needed, particularly for more complex or nuanced cases. However, the process described did not clearly demonstrate a formalised pathway for obtaining and recording second opinions, shared care decisions, or the rationale for clinical advice provided. This was particularly relevant where complex needs or specialist areas of care were involved.

People's health and wellbeing needs were identified through consultation and questionnaire-based review, with reviews included within the initial fee structure. The service stated that care and treatment were tailored to individual patient needs, with patient welfare and safety prioritised. There was reference to evidence-based practice, professional reading, NHS clinical experience and awareness of red flags. Information provided to patients included detailed written communication based on the eight pillars of health and the service would use visual aids, written materials and other resources

to support people with sensory or cognitive needs. The evidence suggested a person-centred approach, although further detail would strengthen assurance about how individualised plans were consistently developed, reviewed and recorded.

The service operated within a defined advisory scope and indicated that patients were directed to their NHS GP, specialist services or emergency services where concerns fell outside this scope or required urgent assessment. Patients were advised of escalation routes from the outset. Where abnormal or nuanced results arose, the clinician may seek peer review input if required. While this provided some assurance that escalation was considered, the evidence did not fully demonstrate a clear, documented procedure for explaining, actioning and managing abnormal results, including how patients were informed, how advice was recorded and how follow-up assured.

The registered manager must:

- **Document how referrals to GPs, specialist services or diagnostic investigations are made, recorded, monitored and followed up**
- **Formalise and document arrangements for second opinions and shared care, including recording peer advice, decisions and the rationale for clinical advice in the patient record**
- **Strengthen its procedure for managing abnormal results, including patient communication, escalation, urgent concerns and recording actions and follow-up.**

Equality, diversity and human rights

The service demonstrated a positive approach to promoting equality, diversity and human rights. There was evidence of comprehensive and up-to-date policies in place, including an Equality and Diversity Policy and Statement of Purpose, which referenced key legislative requirements such as the Equality Act 2010 and Human Rights Act 1998.

The service described a commitment to treating people fairly and without discrimination and consideration had been given to making information accessible to people from a range of backgrounds and with differing levels of health literacy. The availability of translation services, support for people with specific needs and the use of a virtual delivery model helped to support accessibility, particularly for people who may experience barriers to attending appointments in person. It was also positive to note

that cultural needs were considered and that the use of pronouns was encouraged as part of setting an inclusive tone.

Citizen engagement and feedback

The service demonstrated a positive approach to seeking and using the views of people who used the service. Feedback was gathered through a feedback form, supported by periodic conversations with patients, providing opportunities for people to share their experiences and raise any concerns. The service advised that patient feedback was considered regularly and used to inform improvements where required, supporting a culture of continuous improvement and responsiveness to people's experiences.

It was positive that the service had mechanisms in place for people to provide feedback, including in relation to equality, diversity and human rights and that feedback was used to support ongoing improvement in service provision.

The registered manager must share a summary of feedback received and actions taken, through the patient guide or another accessible format, to show how feedback supports service improvement.

Delivery of Safe and Effective Care

Environment

Overall, the arrangements indicate that appropriate measures were in place to safeguard records and maintain the security of the premises. The arrangements in place at the premises demonstrated a positive approach to maintaining a safe, secure and fit-for-purpose environment. Medical records were stored electronically on a two-way verified, password-protected system, with use of the General Data Protection Regulations (GDPR)-compliant clinical system providing controlled client access. The absence of paper records, use of a locked room, secure front door access and laptop-based working arrangements supported good information governance and reduced the risk of unauthorised access to confidential information.

Managing risk and health and safety

The service had arrangements in place for maintaining up-to-date clinical guidance. The service was operated by a single clinician, the RM and responsible individual (RI). They remained current with professional standards and updated clinical guidelines through attendance at conferences and continued professional development (CPD) activities. The clinician was also signed up to receive Medicines and Healthcare products Regulatory Agency (MHRA) safety bulletins, ensuring that safety alerts were received promptly and acted upon. Evidence provided demonstrated that the service undertook some clinical audit activity.

The registered manager must enhance the current audit programme by increasing audit activity and strengthening existing processes to support continuous quality improvement.

Infection prevention and control (IPC) and decontamination

Whilst no patients were assessed or treated on site, we were told the room was uncluttered and the layout allowed for effective cleaning.

This virtual service significantly reduced the risk of healthcare-associated infections. Where any physical examination was required, the service reported that handwashing and equipment cleaning protocols would be followed. Staff also had access to appropriate personal protective equipment and had completed relevant training in its safe use, including donning and doffing. These arrangements provided assurance that infection prevention and control measures were understood and applied when needed.

Medicines management

The service provided clear assurance that medicines were not used within the service and therefore arrangements for ordering, obtaining, storing, controlling, supplying, prescribing, administering, disposing of medicines and maintaining records of medicines administration were not applicable.

The service had an appropriate approach to monitoring relevant safety information, including advice bulletins and alerts issued by regulatory, professional and statutory bodies such as the MHRA and relevant Royal Colleges. This demonstrated a positive commitment to maintaining awareness of patient safety matters relevant to the treatments provided by the service.

Safeguarding children and safeguarding vulnerable adults

The service demonstrated positive arrangements for protecting people from abuse. A safeguarding policy and procedure were in place and up to date. The RM was fully trained as the safeguarding lead. There had been no evidence of allegations of abuse at the service. If safeguarding concerns were identified, the provider stated they would follow the service policy and refer concerns to the relevant local authority safeguarding team.

Safe and clinically effective care

Overall, the service demonstrated positive arrangements for supporting safe and effective treatment and care. The RM had oversight of the development, review and implementation of policies and procedures in line with regulations, with policies covering key areas such as safeguarding, equality and diversity, consent, facilities and equipment, records management, assessment, diagnosis and treatment.

The service also demonstrated that relevant professional guidance, alerts and regulatory updates were accessed through appropriate routes, including the General Medical Council (GMC), National Institute for Health and Care Excellence (NICE), Royal Colleges and HIW. These were maintained within a secure digital repository to support ongoing compliance and good practice.

There was evidence of continued professional development (CPD) through attendance at conferences, webinars, professional meetings and discussions with experts. The RM also participated in an annual appraisal in line with GMC requirements and revalidation standards and had identified a peer reviewer as a further opportunity to support reflective practice and professional assurance.

Participating in quality improvement activities

The evidence reviewed indicated that the service was committed to maintaining safe, effective and person-centred preventive lifestyle medicine services, with clear governance arrangements and a focus on ongoing improvement. The service demonstrated a positive and proactive approach to assessing and monitoring the quality of the services it provided. The service had a range of clearly defined policies and procedures in place, including those relating to risk management, patient care, consent, records management, equality and diversity and these were reviewed regularly to ensure they remained current and reflective of best practice. There was evidence of ongoing quality assurance through regular assessment, clinical review and reflective case analysis, supported by the GMC revalidation processes.

Patient feedback was actively sought and used to inform service development and complaints were documented and investigated to identify learning and improvement opportunities. The service also promoted shared learning through accessible information, including blogs and professional updates, which supported a culture of continuous improvement. The service had appropriate arrangements in place for submitting annual returns to HIW and confirmed that significant events and notifiable incidents would be reported in line with regulations. No reportable incidents were recorded in the preceding twelve months.

Information management and communications technology

The evidence provided indicated that the service had considered the safe and secure management of people's data and information during remote consultations. The service used a recognised video consultation platform and described measures intended to protect confidentiality, including conducting consultations from a private setting, asking patients to confirm they were also in a private environment and restricting access to patient records to the RM only.

The service also demonstrates awareness of relevant professional expectations, including GMC guidance on confidentiality, remote consultations and respectful patient interactions. Positively, the provider had described arrangements for secure communication, including encrypted email for patient-doctor interactions and document exchange. They stated that confidentiality procedures were reviewed to reflect changes in technology, emerging risks and regulatory requirements.

As remote consultation was the only method of consultation offered, the service had a clear and documented process for determining when a remote consultation was clinically appropriate and when a patient may need to be signposted to alternative services or face-to-face care. No images or recordings were made during online consultations, which reduced risks associated with storage, consent and sharing of visual information.

Records management

The service demonstrated a positive approach to the management of people's records, with patient information and consultation notes maintained securely through the electronic health record system. Records generated from consultations were stored electronically, with no paper records held. The use of a secure clinical system supported confidentiality and aligned with UK GDPR and data protection requirements. Access to records was appropriately restricted, with the RM having sole access, which reduced the risk of unauthorised access. The service also described the use of encryption and secure servers, further supporting the safe storage and transmission of patient information.

We were told patient records were retained in line with relevant regulatory requirements, with records retained for a minimum of eight years and longer where required depending on the patient's age, clinical history or individual circumstances. This demonstrated an awareness of the importance of appropriate record retention and secure disposal when records were no longer required. Overall, the arrangements described provided assurance that records were accurate, confidential and managed in a way that supported safe care.

Quality of Management and Leadership

Governance and accountability framework

The service was led by an individual doctor who held the role of RI and RM, with accountability for all decisions clearly resting with them. Whilst working independently, there were peers available to sense-check treatment plans and external professional accountability through the GMC and HIW.

The service had developed a range of written policies covering key areas such as equality and diversity, safeguarding, patient consent, facilities and equipment, records management and assessment, diagnosis and treatment. These were subject to ongoing review to ensure they remained current, accessible and reflective of the service provided.

We found the HIW registration certificate was available on the service website and that the details and conditions of registration were being complied with. The service also confirmed that appropriate indemnity arrangements were in place, providing assurance that the service was adequately covered. This supported a positive view of the governance arrangements in place and suggested that the service had taken steps to meet its responsibilities in relation to leadership, registration and insurance requirements.

Dealing with concerns and managing incidents

The service demonstrated effective processes for managing concerns and complaints. Information about the complaint's procedure was made available to patients through the patient guide, statement of purpose and patients Were also made aware of this during consultations. There was an up-to-date complaints policy which contained the key information expected, including how to raise a complaint, relevant timescales, escalation routes and contact details for appropriate external bodies. There were clear arrangements in place to acknowledge written concerns within three working days and provide a substantive written response within twenty working days, with patients kept informed should further time be required.

The service also demonstrated a positive approach to learning and improvement, with complaints and feedback used to support service development and reduce the risk of recurrence.

In relation to notifiable incidents, the service stated that notifications to HIW were submitted using forms available on the HIW website. The service reported that there had been no reportable incidents in the preceding twelve months.

Workforce recruitment and employment practices

The RM confirmed there were currently no plans in place to recruit, which meant several aspects of the recruitment and ongoing suitability arrangements were not applicable at the time of inspection. However, they demonstrated a good understanding of the expected recruitment process and the importance of completing appropriate pre-employment checks to support the health, safety and welfare of people using the service.

The provider also indicated that, although a recruitment policy was not currently required, one would be developed if recruitment activity became necessary. This demonstrated a responsive approach and awareness of the need to establish appropriate governance arrangements should staffing arrangements change in the future.

Workforce planning, training and organisational development

There were appropriate arrangements in relation to staff support proportionate to the size and nature of the service. The RM was the sole member of staff and therefore arrangements relating to staff induction, staffing levels, supervision, staff meetings and raising concerns were not applicable in the usual way.

We found positive evidence that the provider maintained her professional knowledge, skills and learning through ongoing training, research, conferences, webinars, writing and reflective learning activity, including use of professional learning platforms. Mandatory training was completed mainly through the electronic staff record (ESR) as part of the provider's NHS employment and compliance was monitored through this system.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection			

Appendix B – Immediate improvement plan

Service: **Resilience Health**

Date of inspection: **9 June 2026**

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Findings	No immediate concerns were identified on this inspection	
	Improvement needed	**Standard / Regulation**
1.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: **Resilience Health**

Date of inspection: **9 June 2026**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

	Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There was limited health promotion material available.	The registered manager must strengthen the accessibility and consistency of its health promotion information by ensuring the website and blog content are regularly reviewed, updated and clearly signpost people to appropriate sources of further support.		A documented quarterly content review process has been introduced for all website and blog health promotion material. Each page/post is checked against a review log recording: date reviewed, whether content remains accurate and current, and whether signposting to relevant external support (e.g. NHS 111, GP services, relevant national charities/support bodies depending on topic) is present and up to date. Where signposting is	Registered Manager	First full review and signposting update completed by 15 August 2026. Reviews then repeated quarterly (Nov 2026, Feb 2027, and ongoing).

				missing, it is added at the point of review. Evidence to be provided: the content review log (with first review dated) and screenshots of updated website/blog pages showing signposting.		
2.	The service operates within a defined advisory scope and indicates that patients are directed to NHS general practice, specialist services or emergency services where concerns fall outside this scope or require urgent assessment. Patients are advised of escalation routes from the outset. Where abnormal or nuanced results arise, the clinician may seek peer review input if required. While this provides some assurance that escalation is	The registered manager must: • Document how referrals to GPs, specialist services or diagnostic investigations are made, recorded, monitored and followed up • Formalise and document arrangements for second opinions and shared care, including recording peer advice, decisions and the rationale for		A Referral Log has been introduced within the clinical system, recording for every referral: date, recipient (GP/specialist/investigation), reason, method of communication, and date the referral was confirmed received/actioned. This is checked at each relevant follow-up consultation. A written Second Opinion and Shared Care Protocol has been developed, setting out when peer input will be sought, the peer network/anonymised professional discussion route used, and a requirement that the date, content and outcome of that	Registered Manager	All three documents drafted and in use by 22 August 2026. First use of each reviewed as part of the Q3 2026 clinical audit, due by 30 September 2026.

	considered, the evidence does not fully demonstrate a clear, documented procedure for explaining, actioning and managing abnormal results, including how patients are informed, how advice is recorded and how follow-up is assured.	clinical advice in the patient record • Strengthen its procedure for managing abnormal results, including patient communication, escalation, urgent concerns and recording actions and follow-up.		discussion (including the rationale for any resulting clinical advice) is recorded in the patient's clinical record. A written Abnormal Results Management Procedure has been developed, setting out how an abnormal result is identified, the timeframe for informing the patient (same day for urgent/red-flag results; within 2 working days for routine abnormal results), how advice given is recorded, and how escalation to a GP, specialist or emergency service is actioned and followed up. Evidence to be provided: copies of the Referral Log template (with example entries), the Second Opinion and Shared Care Protocol, and the Abnormal Results Management Procedure, plus confirmation these have been used in practice.		

3.	Mechanisms were in place for people to provide feedback and that feedback is used to support ongoing improvement in service provision. However, it is not displayed anywhere.	The registered manager must share a summary of feedback received and actions taken, through the patient guide or another accessible format, to show how feedback supports service improvement.		A new section has been added to the Patient Guide summarising the themes arising from patient feedback received and the specific changes made to the service as a result. This section will be updated at each Patient Guide review, and following receipt of any new feedback with a notable theme, so it remains current. Evidence to be provided: the updated Patient Guide showing the new feedback summary section, dated.	Registered Manager	Feedback summary section added to the Patient Guide by 15 August 2026, and reviewed alongside each future Patient Guide review.
4.	There was evidence of some audit activity, from which, areas for improvement were identified.	The registered manager must enhance the current audit programme by increasing audit activity and strengthening existing processes to support continuous quality improvement.		A formal Clinical Audit Process has been implemented (June 2026), introducing a quarterly audit trigger (a formal audit is completed whenever two or more patients are seen in a calendar quarter), defined audit areas (consent, records, assessment and recommendations, referrals, feedback,	Registered Manager	Process implemented June 2026 (already in place). Q2 2026 entry completed by 31 July 2026. Q3 entry by 30 September 2026, Q4

				complaints/incidents, safeguarding, and policy compliance), and a Quarterly Audit Log. Where the quarterly volume threshold is not met, this is recorded, and reflective review is instead completed through the GMC annual appraisal cycle, which is externally reviewed by the responsible officer. The outstanding Q2 2026 log entry is being completed, and the log will continue to be completed each quarter, with a first Annual Review Summary completed at year-end. Evidence to be provided: the Clinical Audit Process document and the completed Quarterly Audit Log (Q1–Q4 2026 entries).		entry by 31 December 2026, and first Annual Review Summary by 31 January 2027.

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Job role: Registered Manager / Registered Individual **Date:** 24/07/26